PERMANENT PARTIAL DISABILITY

EVALUATIONS UNDER THE ILLINOIS WORKERS’ COMPENSATION ACT

Michael E. Rusin

Rusin Maciorowski & Friedman, Ltd.
10 South Riverside Plaza, #1530
Chicago, IL 60606
(312) 454-5110
2008

merusin@rusinlaw.com
www.rusinlaw.com
Introduction

Determining a permanent partial disability rating is not an easy matter in the State of Illinois. The Workers’ Compensation Commission jealously protects its right to evaluate and determine the extent of permanent partial disability. The Commission does not rely on any written or published standards. Many states base their determinations of permanent partial disability on guidelines published by the American Medical Association, the American Academy of Orthopedic Surgeons or some other generally recognized medical association. The Commission does not use such guidelines. In fact, opinions based on such guidelines are inadmissible in proving the extent of permanent partial disability.

Further, the Commission does not allow testimony or narrative reports from any doctor as to the percent of disability incurred by the claimant. The Commission regards such opinions as an invasion of its right to determine the extent of permanent partial disability. Consequently, for an individual unfamiliar to the Illinois workers’ compensation system, it is difficult to accurately estimate the extent of the permanent partial disability award which may be rendered by the Workers’ Compensation Commission. Even for those who have been handling cases for many years, an estimate of permanent partial disability is not precise.

There are no books or articles (other than this one) which provide expert guidance in evaluating permanent partial disability. The only reference materials available to the adjuster and practitioner are prior Workers’ Compensation Commission decisions. In 1980, as a result of statutory changes, the Commission was first required to issue written decisions setting forth findings of fact and conclusions of law. Prior to the publication of written decisions, estimates as to permanent disability were based only on experience. The publication of decisions provides an excellent resource tool and makes the determination of permanent disability somewhat less of a guessing game. There is no official reporter for Workers’ Compensation Commission decisions. There are companies which publish indexes of Workers’ Compensation Commission decisions. These indexes provide a good reference to identify Commission decisions which may be similar to the case you are handling. However, as with all summaries, there are frequently facts contained in the decision which are not reflected in the summary. Moreover, it must be recognized that the cases that are tried to decision generally involve the more severe injuries and especially those where claimants wish to keep their medical rights open. Consequently, the percentage awards for those types of cases tend to be higher than the settlements reached for similar injuries involving better recoveries.

Because there are no fixed standards against which the Commission makes permanent disability awards, the amounts of the awards and the percentages of disability have changed over the years as the decision-making personnel have changed. Although past decisions are to be precedent for subsequent Commission decisions, each of the commissioners and especially the arbitrators believe their individual assessment of permanent disability is more accurate than what may have been previously awarded. This is especially problematic now since there have been so many personnel changes in the last five years. Currently, 6 of the 9 Commissioners are essentially brand new. There are now
three independent panels of Commissioners hearing cases. The chance of conflicts between the Commission panels is high. In the last few years, the Commission has added 14 new arbitrators, most of which were previously employed as petitioner’s attorneys.

Statutory Authority

There are three different sections of the statute which provide for awards of permanent disability following an accidental injury. This article will analyze only awards for permanent partial disability, ignoring those cases of permanent total disability or wage differential. The sections involved are §§8(c), 8(d)(2), and 8(e).

The new statute changed the number of weeks available for PPD by 7.5% across the board except for awards for loss of use of the man as a whole. These changes are effective for accident dates 7/20/2005 to 11/15/2005 and 2/1/06 and thereafter.

Awards under §8(c) can be made for serious and permanent disfigurement. In order to qualify for a disfigurement award, the disfigurement must be to the hand, head, face, neck, arm, leg below the knee, or chest above the axillary line. The maximum disfigurement award for an injury is 162 weeks of permanent partial disability compensation. An award can be made for either disfigurement or disability, but not both.

Section 8(d)(2) provides for awards of permanent disability to the "man as a whole." The maximum compensation which can be awarded is 500 weeks. This section normally applies to all neck and back injuries as well as other injuries to the head, ribs, internal organs, etc. It also covers all alleged psychological or psychiatric injuries. There are no specific credit provisions in §8(d)(2). Consequently, an employee can receive multiple §8(d)(2) awards even exceeding 500 weeks of compensation. This is an outrageous and ridiculous result, but according to our courts, it is legal. Consolidated Freightways v. Workers’ Compensation Commission, 237 Ill.App.3d 549; 604 N.E.2d 962 (1992).

Section 8(e) provides a schedule of benefits for extremity injuries. Each extremity is assigned a specific maximum number of weeks in the event there is a total loss of use or amputation. There is a specific credit provision in §8(e)(17). That provision states that an employee cannot receive an award in excess of 100% loss of use of a member. In the event of multiple accidents with injuries to the same member, credit is given in the amount of the prior award against any subsequent awards or settlements. The amount of credit which is given is based on the percent of disability, not on the dollar amount of the prior settlement or award.

Rates

The permanent partial disability rate is calculated by taking 60% of the employee's average weekly wage. The permanent partial disability rate is subject to various minimums and maximums as set forth in the statute. The permanent partial disability rate cannot exceed the employee's average weekly wage. The maximum permanent partial disability rate increases annually. The date of every increase is July 1, although the new rate does not go into effect until it is published. The
new rates are not published until the December following the July 1 increase. If a settlement or award is made using the old rate, the claimant is not entitled to an adjustment.

The 2005 statute imposes new minimum rates effective for dates of accident after 2/1/2006 which are much higher than the old minimums. The new TTD and PPD minimums became:

- Single – $173.33
- Single +1 - $199.32
- Single +2 - $225.32
- Single +3 - $251.32
- Single +4 - $260.00 (Max)

Furthermore, the State minimum was increased to $7.50 an hour on July 1, 2007 and the TTD and PPD minimums were further increased to:

- Single - $200.00
- Single +1 - $230.00
- Single +2 - $260.00
- Single +3 - $290.00
- Single +4 - $300.00

The new statute increases by 7.5% - the number of weeks of PPD available for all scheduled body parts except for Man as a whole.

**Factors Used in Evaluating Permanent Disability.**

There are numerous factors which go into the determination of a permanent partial disability award. Although the final medical evaluation is important, it is neither the only nor even the most important factor. The various factors the Commission considers are as follows:

1. **Nature of accident.** The Commission will tend to award higher percentages of permanent disability to accidents which are more severe. A significant accident with minimal actual disability may be treated the same as a rather minor accident which causes more significant disability.

2. **Nature of initial injury.** The nature of the initial injury is the most significant factor in the determination of permanent partial disability. Irrespective of final results, the fact that an accident caused a fracture or torn meniscus or herniated disc or carpal tunnel syndrome will be the most significant determining factor in the percentage of permanent disability awarded. To a great degree this becomes a necessity for the Commission. With the volume of cases handled, the Commission's job becomes much easier if certain types of injuries have recognized values. It is quicker and easier to evaluate a case based on the nature of the injury rather than review extensive medical records and a final medical report which doesn't include a permanent disability rating.

3. **Amount of lost time.** The Commission views the amount of lost time as a significant factor in evaluating permanent disability. The Commission awards higher permanent disability to those claimants who are off work the longest. The greater the period of TTD results in a greater award of PPD. This is especially true in spinal injuries and strain/sprain type injuries. Since simple
neck and back strain cases tend to result in no objective findings, the Commission frequently views the amount of lost time sustained as an indicator of the severity of the injury. That analysis translates also into extremity injuries, but not to as great a degree. Clearly, permanent disability awards are significantly lowered where the claimant returns to work sooner rather than later. Therefore, aggressive return to work programs are great cost saving programs not only as to TTD and medical expenses but also as to PPD liability.

4. **Current physical objective findings.** For obvious reasons, an individual's current physical objective findings after he reaches MMI are critical in an assessment of permanent partial disability. The Commission is specifically looking for findings concerning range of motion, strength, and neurologic function. It is critical in obtaining an evaluation report that a physician provide you with detailed objective findings, both positive and negative. Not unexpectedly, the Commission places greatest emphasis and reliance on reports of quality treating physicians as compared to independent medical examiners. The Commission places greater emphasis on the reports of those physicians who are specialists. The Commission rarely retains its own examining physician. Although the Commission has a right to do so under the Act, the Commission rarely schedules its own independent evaluation. Instead, the Commission chooses to rely on the reports and medical records submitted by the parties.

5. **Petitioner's ability to return to regular work.** If a claimant is able to return to his regular job and earn his regular wages that fact will tend to lessen (but not eliminate) the Commission's PPD award. If petitioner is only allowed to return to limited work and/or may have reduced wages that factor will significantly increase a permanent partial disability award. Even if the Commission ignores any wage differential consideration, they will render a higher permanent disability award in an effort to make up for the wage loss. The Commission may convert an extremity award under Section 8 (e) to a man as a whole award under Section 8 (d) (2) if petitioner does not return to his regular work duties.

6. **Description of job.** Claimants who have heavier, more strenuous jobs tend to get higher awards of permanent disability. The Commission will generally take into account how much more difficult an injury makes an employee's ability to perform his job. Claimants with lighter, less physically demanding jobs tend to obtain lower awards.

7. **Amount of average weekly wage.** The permanent disability system in Illinois is skewed in favor of high wage earners. Claimants earning high wages receive much higher dollar awards of permanent disability than do their lower wage counterparts. To a certain extent the Commission has taken this into consideration and awarded higher percentages of disability for lower wage claimants to make up for the disparity in the dollar amount of the award created by the low wage. However, this practice may stop given the higher minimum rates. The reverse scenario is not true. However, the Commission will not reduce the percentage of PPD given to high wage earners.

8. **Current subjective complaints.** Claimants who complain more and better get higher awards. Despite minimal physical findings, a claimant who testifies extensively and well as to numerous subjective problems is much more likely to obtain a higher award than a similar claimant with the same physical findings and reports more limited subjective complaints. Whiners get more and honest non-complainers get less.
There are other factors which the Commission takes into consideration in evaluating permanent partial disability, but they tend to be more difficult to use as a predictor of liability. For example, the Commission frequently states that the age of the petitioner is an important factor in the determination of permanent disability, but it is unclear how they use this factor. On the one hand, if a claimant is young, the award of permanent disability can be higher because he has more years to live with the injury, or it could be lower because the youth of the claimant helps the healing process. Alternatively, an elderly claimant could be awarded more because he does not have the ability to heal as well, or he could be awarded less since he does not have to live with the condition as long. Consequently, age is an unreliable factor, except to say that those in middle age get less.

One of the most significant factors in evaluating permanent partial disability where an application has been filed is the arbitrator to whom the case is assigned. Some of the arbitrators are known to be conservative in their permanent disability awards. Many are known to be extremely generous (liberal). Some attempt to follow Commission precedents closely and rely on Commission decisions extensively. Others rely solely on their own expertise with little concern as to what the Commission has done in the past or may do with the specific case at issue. In the past when many arbitrators disagreed with Commission precedents, they wrote higher awards simply as a challenge to the Commission to alter them. Questions concerning individual arbitrators should be directed to me.

Evaluate the Body

Look to see what part of the body is injured and accept these general rules.

1. Distal injuries are worth less than proximal injuries.
2. Medial injuries are worth more than lateral injuries.
3. Weight bearing joints are compensated more than non-weight bearing joints.
4. Multiple injuries to multiple body parts result in discounts.
5. Surgery performed – award is higher - arthroscopic surgery gets less than open surgery.
6. Pretty women get more than ugly men.

Specific Case Situations -- Permanent Partial Disability

Hands and Feet.

The Commission generally treats injuries to the hands and feet in a similar manner when awarding permanent partial disability. The maximum number of weeks is approximately the same. The nature of the internal structures in the hands and feet are similar.

Simple lacerations without lost motion or significant lost sensation are generally not compensable for permanent disability. An award might be made for disfigurement. A fracture to the distal phalanx of either a toe or a finger is worth approximately 10-15%. Conceivably, an award could be up to 15%-20% loss of a finger. The amount of permanent disability awarded for a finger fracture increases if the fracture is in the middle or proximal phalanx. In such a circumstance the awards are more in the range of 20%. Multiple fractures within a finger or compound fractures will
result in awards in the 30%-40% range depending on the severity and the result. If an injury results in a dislocation as well as a fracture, the award is 5% to 10% higher. Great toe fractures are compensated at lower percentages than other toes because of the greater total value.

Finger and toe amputations are treated specially by statute. If the accident involves an amputation of the entire bone or simply a significant portion of the bone in the distal phalanx, the claimant is entitled to a minimum 50% award. If the injury results in an amputation without bone loss, the 50% minimum does not apply. If the amputation involves bone loss beyond the distal phalanx, an automatic 100% loss of use is awarded. If petitioner sustains a crushing injury to the finger with a comminuted fracture and surgery is required to remove bone fragments, the removal of bone fragments does not constitute an amputation. Bone loss does not automatically mean amputation. There must be a shortening of the member to qualify as an amputation. An amputation of the tip of a finger or toe without bone loss does not merit an automatic 50% award.

In undisputed amputation cases, the Commission requires that the employer begin to pay weekly permanent partial disability as soon as TTD has ended. The failure to pay the undisputed permanent disability promptly may result in an award of Section 19(k) penalties (50%). Also, keep in mind that the arbitrator may order the purchase of prosthesis even if only for cosmetic purposes.

Cases involving injuries which lead to mallet deformities usually result in significant awards in the range of 25%-50% of a finger. Injuries resulting in trigger fingers which require surgery generally result in awards in the range of 20%-30%.

A frequent injury to the thumb is a torn extensor tendon or collateral ligament. If surgically repaired, the award is 40%-50% of the thumb.

Contusions generally do not result in awards of permanent disability unless there is significant evidence of permanency. Fractures involving the metatarsals or metacarpals are generally considered less serious than fractures in the wrist or ankle. Consequently, they result in lower awards. There is a fairly wide range of Commission decisions as to the extent of permanent disability awarded for a single metacarpal fracture. Clearly, a 5th metacarpal fracture is considered the least serious. Most awards tend to be in the 10%-15% range. Fractures involving the 2nd and 3rd metacarpals are considered more serious. Those awards are more in the range of 10%-20% of the hand.

Simple fractures in the wrist generally result in awards in the range of 15%-20% of a hand. A Colles fractures in the wrist (fractures of both distal radius and ulna) is considered serious. The lowest reported decision is 25% of a hand. The highest reported decision is 50% of a hand. Most awards tend to be in the range of 30%-35% of a hand. The awards tend to increase if surgery is required or if the fracture remains ununited. They are lower if closed reduction is possible with good fragment positioning and solid bony healing.

In a similar vein, a single malleolar fracture in the ankle will generally result in an award between 15% and 25% of a foot. A bimalleolar fracture will result in a 25%-40% award. A trimalleolar fracture will result in an award between 40% and 75% loss of use of a foot. Again, the
ability to reduce such fractures without surgery generally results in a lower award. If the surgery results in an arthrodesis, the awards are between 60% and 75%.

Fractures to the os calcis (calcaneus) are not considered as serious as they were in the past. Awards range from 15%-35%. Plantar fasciitis cases non-surgical are generally in the 5%-10% range.

Repetitive hand and wrist injuries are very common. It is difficult to avoid liability for carpal tunnel syndrome where a claimant's job duties are in any way repetitive. Permanent disability awards for carpal tunnel syndrome where there has not been surgery are generally in the 5%-10% range. If surgery is performed, the awards are generally in the range of 15%-20%. There are awards as low as 10% and as high as 25% but those are exceptional. As a general rule, the dominant hand may get an extra 2 1/2%. The most standard award in a CTS surgery case is 17 1/2% to 20% for the dominant hand and 15% to 17 1/2% for the non dominant hand. The most standard settlement is 15% of each.

Injuries resulting in ganglion cysts are not considered nearly as disabling. Even in cases involving surgery, the awards are generally in the 5%-10% range. Cases involving DeQuervain's tenosynovitis are treated similar to those involving carpal tunnel syndrome but the awards are significantly more varied. They range from 10% to 30% depending on numerous factors and results.

Strains and sprains of the hand, wrist, foot and ankle are frequently compensated for permanent disability despite no objective findings. Depending on the period of lost time, the awards are generally in the range of 5%-10%.

**Arm Injuries.**

Cases involving fractures to the distal radius and ulna are compensated on the basis of loss of use of a hand. However, if the fracture occurs more proximal to the wrist joint, an award is made based on loss of use of an arm. Mid-bone fractures generally do not result in significant permanent disability awards. A mid-bone fracture can be as low as 10% of an arm. Fractures to the radial or ulnar head (at the elbow) are compensated higher in the range of 15%-25% of the arm. Fractures to the humerus tend to be serious. If surgery is required, the awards are in the range of 40%-70% of an arm.

A rupture to the biceps will generally result in an award of 15%-25% of an arm depending on severity, provided surgery is not needed. If surgery is performed, the awards are generally in the range of 25%-35% loss of use of an arm. A rupture of the triceps is rarer but is compensated in the same range.

Elbow injuries that are most commonly seen involve epicondylitis, fractures to the olecranon, and ulnar nerve injuries. Cases involving epicondylitis without surgery are generally in the 5%-10% range. If surgery is required for either medial or lateral epicondylitis, awards are generally in the range of 15% to 20% of the arm. Fractures of the olecranon which heal without surgery are generally in the range of 15%. If surgery is performed, the disability is usually in the range of 20%.
Frequently, nerve impingement at the elbow occurs and the diagnosis is made of ulnar nerve entrapment or cubital tunnel syndrome. These cases require surgery to relieve the impingement and repositioning of the nerve. Cases involving ulnar nerve transposition result in awards of 15%-20% loss. Awards are higher if a post surgical EMG/NCV shows continuing nerve damage or if multiple surgeries are necessary. If the condition is diagnosed but surgery is not required, awards are in the range of 5% to 10% of an arm.

The most common injuries to the shoulder involve adhesive capsulitis, impingement syndrome or tears in the rotator cuff. Cases involving adhesive capsulitis generally range from 15%-20% of an arm. This presumes that the treatment includes a manipulation under anesthesia. Cases involving impingement syndrome vary significantly depending on severity. If the diagnosis is made and only conservative treatment is given, awards are 10% to 15% of an arm. If surgery is required (acromioplasty, distal clavicle excision), awards are in the range of 15% to 25%.

Cases involving rotator cuff tears with successful surgical repair generally result in awards in the 25%-30% range. If an acromioplasty is performed in addition to a rotator cuff repair, the awards tend to be higher and more in the range of 30%-35% of an arm. Frequently, in addition to a rotator cuff tear, an individual will have other injuries as well including an injury to the biceps, the labrum or adhesive capsulitis. Further, there may be ligament instability which requires repair or tightening. Such multiple conditions push awards to the higher end of the ranges. Multiple surgeries produce even higher awards.

Cases involving dislocations where there is no surgery involved generally result in awards of 10%-20% of an arm. If surgery is involved, awards are more in the range of 25%-35% of an arm.

**Leg Injuries.**

Leg fractures are compensated in a manner similar to arm fractures. Fractures near the ankle are compensated on the basis of loss of a foot. Fractures higher in the leg are based on loss of the leg. Fractures to the femur are generally serious. Most awards involving surgery are in the range of 50%-75% of a leg. Individual fractures of the tibia or fibula will result in awards of 15%-20% of a leg provided the fracture is simple. If it is compound, comminuted or spiral, the awards can increase to 25%-35%. Hip fractures generally result in awards in the range of 25%-30% loss of use of a leg. Hip fractures with bad results such as those cases involving aseptic necrosis or total hip replacement are compensated at a much higher level. Hip replacements are generally awarded 45% to 60%. A fracture to the patella is difficult to assess because of widely varying recoveries. Awards range from 10%-45%.

Most leg injuries involve the knee. Simple contusions result in awards of 0-5%. A strain with diagnosed chondromalacia may result in an award of 10%-15%. Cases involving a single meniscus tear which is surgically repaired generally result in an award of 15 to 20% of a leg. The lowest award is generally 15%. Such a result is more likely if petitioner holds a clerical position or light duty position. If both the medial and lateral menisci are torn, the awards are in the range of 25%-35%. The same result occurs if there is also a diagnosis of chondromalacia of either the patella or the condyles. Cases involving both a meniscus tear and a ligament tear generally result in awards of 30%-40% loss of use. A ligament tear with surgical repair usually is rated at 25% to 35%. If a
patellectomy is performed, the award will likely be in the range of 60%. If a total knee replacement is done, the award will likely be in the range of 40%-60%. If a fracture has occurred in the tibial plateau and surgery is required for internal fixation, the award will likely be in the range of 50%.

Advanced surgical techniques have now affected PPD awards. In the past, knee replacements and hip replacements were considered rare and unusual. Now they are commonplace and the Commission is finally recognizing that such surgeries do improve function. Moreover, they last a long time. Therefore, the awards for PPD have decreased. Awards for knee injuries do vary depending on whether surgery is done by arthroscopy or arthrotomy. This tends to be true for all surgical cases where less disability is awarded if the surgery done is less invasive than a full open procedure.

**Spinal Injuries.**

Cases involving injuries to the neck and back are both the most common before the Commission and the most difficult to evaluate. In cases involving simple back strains with minimal lost time and minimal medical treatment, the awards range from 0-2% of the man as a whole. The automatic award for every back strain no longer exists. The Commission decisions are full of zero awards where the cases were minor. In the slightly more significant cases, the awards range from 2% to 4% MAW.

The more significant strains generally result in awards from 4%-10% loss of use of the man as a whole. Such awards are common where the only diagnosis made is that of a strain. It is rare for an award to be rendered over 7.5% of the man as a whole where all diagnostic tests are negative.

In evaluating permanent disability beyond simple strains, the Commission is looking to the plethora of various diagnostic tests used to evaluate back injuries. The Commission will look to x-rays, CT scans, myelograms, post-myelogram CT scans, EMG/NCVs, MRIs, SSEP tests, discograms, etc.

If a claimant sustains a back injury with definite evidence of a herniated disc but no surgery, he will generally obtain an award somewhere in the range of 7 1/2%-15% of the man as a whole. It is difficult to pinpoint exactly where the decision will come in those types of cases. All of the various factors enumerated above come into play. Spinal injuries have the greatest variation in awards depending on the factors mentioned since the objective findings tend to be fewer than the subjective complaints. If a claimant sustains a herniated disc in the lumbar spine which results in a single level laminectomy and discectomy, he will likely obtain an award of 20% of the man as a whole. The lowest such awards are 17 1/2%. It is rare for such awards to exceed 25% if there has been a good recovery. If surgery is not performed but instead petitioner receives a chymopapain injection (with a good result) or an IDET procedure, the awards are in the range of 15%-17 1/2%. If not a good result, the awards increase to 20%-25%.

If the injury results in two herniated discs with surgery at both levels or petitioner has instability and requires a fusion, the awards are generally in the range of 25%-35%. A single level fusion is usually 25% MAW. Additional levels are regularly 5% extra for each level. The PPD
awards are usually higher with respect to cervical spine injuries compared to lumbar spine injuries. Awards tend to be 2 ½% to 5% higher in the cervical spine.

**Miscellaneous injuries.**

Cases involving head trauma are difficult to evaluate. Head contusions without objective findings and with complaints of headaches usually result in no award. Cases involving diagnosed post-concussion syndrome without significant findings generally receive awards of 5%-10% of the man. If a head injury results in a fractured skull, petitioner is entitled to a minimum award of 6 weeks of compensation. However, the Commission generally will award permanent disability of at least 4% and up to 10%. Head injuries leading to seizures can result in significant awards of 30%-40%. Head and facial injuries which result in tooth loss generally get awards in the 1% to 3% range.

Cases involving heart attacks are more frequent than before. The standard of proof for compensability is low. Cases involving a myocardial infarct with a return to work are generally compensated in the 10%-20% range. If bypass surgery is performed, the awards are more in the range of 25%-35%.

Cases involving inguinal strains or hernias no longer generally result in zero awards of permanent disability. In most cases, permanent disability is awarded in the range of 2%-3%. Sometimes awards are as high as 4% to 5% MAW if there has been a poor result. However, for an award of permanent disability in a hernia case, there needs to be proof of a permanent disability. The Commission almost always awards PPD if the surgery includes the use of the mesh implant. The Commission currently believes that the use of mesh must mean that the hernia is a bad one that cannot be corrected without an implant. The reality is the mesh is used at the discretion of the surgeon, not as a result of severity.

Eye injuries are difficult to evaluate. The most significant issue is whether petitioner wore corrective lenses before the accident. As a general rule, if petitioner did not wear corrective lenses before the accident, the Commission will evaluate disability comparing uncorrected vision before the accident to uncorrected vision after the accident. If prior to the accident the petitioner wore corrective lenses, the Commission will generally evaluate permanent disability based on corrected vision before the accident compared to corrected vision after the accident. As a general rule, the Commission awards permanent disability based on loss of visual acuity in conformance with the Wisconsin Eye Chart. This means that 20/20 vision results in zero permanent disability. A loss of vision to 20/200 results in an award of 100% loss of use. However, the Commission will also award permanent disability even though there has been no loss of visual acuity if the injury results in other eye problems such as light sensitivity, tearing, scarring, etc.

Ear injuries are the easiest to evaluate since it is the one member for which there is a statutory standard. The statutory standard is contained in §8(e)(16) of the Act. In evaluating loss of hearing an audiogram is necessary. The audiogram must reflect hearing levels at the 1000, 2000, and 3000 cycles per second. To determine whether there is hearing loss, the average in decibels is calculated in the three different frequencies. If the average is 30 decibels or less, no permanent disability is awarded. If the average exceeds 30 decibels, the amount in excess of 30 decibels is multiplied by 1.82% to determine the percent loss of hearing in each ear. For example, if the
average at the three frequencies is 40 decibels, to determine the percent of hearing loss you must subtract 30 from 40, which equals 10, and multiply 10 by 1.82% to arrive at a percentage hearing loss of 18.2%.

Multiple injuries to various body parts are frequently compensated based on a percent loss of use of a man as a whole. As a general rule there will be some discount in terms of total disability. The Commission usually does not simply add up the various injuries as if they had been sustained individually. For example, if an injury results in an ulnar nerve transposition and a carpal tunnel surgery, it is unlikely that the Commission would award 20% loss of use of an arm plus 15% loss of use of a hand. It is more likely that an award would be entered in the range of 25% loss of use of an arm. However, in serious injuries the Commission will double up and triple up to make the award bigger. The Commission will award a percent of disability for each body part injured and then in addition make an award for a percent loss of use of the man as a whole. However, the Commission does not believe that it is limited in awarding PPD for separate injuries to an arm or leg. The Commission has made separate awards for the hand and arm when both are injured in the same accident. The same result could apply to the leg and foot.

CONCLUSION

The method and manner of evaluating permanent partial disability in Illinois is a complex one. The practice is difficult because objective standards are not applied to evaluate PPD. There is no prospect that PPD evaluations will change at any time in the near future. It is extremely unlikely that any type of standards will be imposed by the Commission. The attorneys don’t want any change. The difficulty in evaluating PPD makes the issue more litigious and keeps the attorneys in practice.

The value of cases changes as personnel at the Commission change. New personnel apply old standards but also create their own. It is critical to always evaluate your case based on the arbitrator to whom the case is assigned and the Commissioner to whom the case will be assigned on appeal. You must take into consideration change while a case is pending as well as when initially assigned. Personnel change frequently and cases must be monitored accordingly.

PPD assessments are somewhat scientific and somewhat of an art form. In order to have success in negotiating or trying a case, the adjuster and attorney need to create as good a picture of the claimant as possible. The adjuster can help the attorney by obtaining as much information as possible to show that the claimant has made a good recovery both at work and at home. This information will give ammunition to the attorney to obtain the most favorable result possible.